FISCAL NOTE

HB 116 - SB 666

March 5, 2001

SUMMARY OF BILL: Requires health insurance companies to disclose the terms and conditions of plan arrangements including a list of providers, prior authorization requirements, financial arrangements with providers, limits on drug formularies and out of plan restrictions. The bill requires insurers to accept *any willing provider* who agrees to accept the terms and conditions, fees, utilization regulations and quality standards unless the insurer makes a written determination that a provider has a history of unprofessional conduct or a pattern of malpractice. No insurer may terminate a provider without cause and the bill requires an appeal mechanism for providers including arbitration. Requires direct access for enrollees to dental services, eyecare/vision services and ob-gyn services without approval of a primary care physician or gatekeeper. Allows civil action by a provider or enrollee when an insurer violates the act.

ESTIMATED FISCAL IMPACT:

Increase State Expenditures - Exceeds $30,000,000
Increase Local Govt. Expenditures* - Exceeds $5,000,000
Other Fiscal Impact – Increase Federal Expenditures – Exceeds $60,000,000

Assumes that the provisions of the bill will result in an estimated increase in capitation rates paid in the TennCare program, an increase in expenditures to the state employee health plan, and increased expenditures to local government health care plans.

The estimate is based on the following:

- An incentive presently exists for health care providers to accept set fee schedules or agree to discounts against usual and customary fees in order to be a part of large health care plans.
- Even though contracts with health care providers may not specifically guarantee a volume of patients, it appears logical on the part of the provider to conclude that such plans bring with them incentives or mandates for plan members to use providers in the plan.
- Allowing an increased number of providers into a plan reduces the likelihood that a provider will receive an increased amount of business and removes or reduces the incentive to provide specified discounts.

- Allowing an increased number of providers into a plan will increase administrative costs to HMOs and health insurance plans.

The Tennessee General Assembly's Special Study Committee on the Tennessee Patient Advocacy Act of 1997 found that any willing provider legislation would lead to increased expenditures to TennCare of $97,632,000 and $9,439,546 to state and local government employee health plans.

*Article II, Section 24 of the Tennessee Constitution provides that: *no law of general application shall impose increased expenditure requirements on cities or counties unless the General Assembly shall provide that the state share in the cost.*

CERTIFICATION:

This is to duly certify that the information contained herein is true and correct to the best of my knowledge.

James A. Davenport

James A. Davenport, Executive Director